HEAD TRAUMA AS A CAUSE OF INSANITY. C. W. Burr (Journal A. M. A., Jan. 5, 1907).

The author asserts that, excluding traumatic epilepsy and hemiplegia with their resulting mental disorder, injuries to the head will not cause insanity unless some predisposition exists. His reasons for this belief are that the vast majority of those suffering from brain injury do not become insane unless there is such a loss of brain substance as to produce dementia from that fact alone, and the rarity of mental disorder following extensive operations on the brain in which lesion of the organ is much greater than that of any ordinary trauma. That head injuries can be a directly exciting cause when predisposition exists or in senility, or that they may aggravate or revive an insane tendency is not to be denied. As regards the claim that there is a characteristic form of post-traumatic insanity, he says it can certainly be denied. The usual types are confusion, delusion, simple dementia and epileptic insanity. He has never seen paranoia or true melancholia following a head injury. He excludes from consideration all cases of post-traumatic delirium, transitory or rapidly followed by death from exhaustion, and all cases in which the physical injury was so trifling or the mental shock so slight that the trauma was a mere coincidence. The only cases considered are those in which the relation of the time between the injury and the onset of the insanity was so close as to make it reasonable to assume that there was something more than mere coincidence. The exact relation between early trauma and late insanity is difficult to ascertain on account of the lapse of time and the usual vagueness of the histories, but he has never seen a case in which other causes than the injury could be excluded. A number of case summaries illustrating the author's views are given in the article.

THE ETIOLOGICAL ROLE OF THE VASOMOTOR CENTERS IN CARDIAC NEUROSES. R. Pollard (Zentralblatt für Innere Medizin, Jan. 12, 1907).

Dr. Rudolf Pollard, after an interesting dissertation, gives us the following conclusions of his observations: (1) There is a group of diseases, chiefly chronic, whose symptoms may be recognized by a preponderating participation of the blood vessels, or rather the blood vessels of the nervous system. To this group belong the heart neuroses, paroxysmal tachycardia, Bassedom's disease, the angioneuroses of the skin, etc. (2) The source of these disorders is an abnormally increased irritability of the vasomotor centers in the medulla. (3) The resulting condition of the heart and the vascular manifestations are in the way of a reflex which may be elicited through peripheral as well as central (brain) irritation. (4) Thereto, further, a reflex sensory tract is necessary; the reflex processes (probably on account of retarded influences at the surface of the brain) may appear under circumstances at first, after the expiration of a certain time (late reflex) and are not strictly confined to the location of the irritation.

ATWOOD (New York).

PAROXYSMAL TACHYCARDIA. By John Hay (Edinburgh Medical Journal, January, 1907).

Symptomatic tachycardia is caused most frequently by a diminution of the normal inhibitory influences. Pyrexia, certain infective conditions, alcohol, atropine and thyroid, may produce the condition, as well as direct stimulation of the accelerator fibers or of the heart muscle. "Paroxysmal" tachycardia, on the other hand, is doubtless of nervous origin, but "during a paroxysm there is an essential and fundamental change in the mode of cardiac contraction, the heart beats in a manner specifically different from that normally found." Three cases are detailed, careful tracings of which are reproduced and explained. The author suggests that "certain nervous influences alter the condition of the heart muscle, and more especially the fibers joining the auricles and ventricles, rendering them more excitable and more capable of stimulus production." Traumatism affecting the heart, physical stress or strain is mentioned as the most exciting factor. In Hay's first case the first paroxysm came on after a severe blow over the epigastrium and lower end of the sternum received in a game of football. Some subsequent attacks in the same case followed physical stress, and others seemed to have no assignable exciting cause. Paroxysms lasted from some hours to eight days. The symptoms were usually severe and distressing. The other cases were milder; one was in a child of six and the other in a man of forty-two. The author quotes that Hoffman believes that these attacks are of the nature of cardiac epilepsy, but that in thirteen autopsies of such cases no lesion was discovered either in the central nervous system nor in the vagus or sympathetic nerves. Hoffman agrees that abnomal cardiac contraction is a distinct feature of the paroxysm. Wenckebach is quoted as suggesting that the stimulation of the central nervous system results in a great increase of the chrontropic and bathmotropic influences playing on the heart. ATWOOD ('New York).

JOINT AFFECTIONS IN NERVOUS DISEASE. By L. F. Barker (Journal A. M. A., Feb. 2, 1907).

Four types of joint disease in nervous affections are considered. The first of these, the intermittent joint effusions, he considers closely related to the angioneurotic edema of the skin and mucous membranes. The danger is in these cases that a mistake in diagnosis may lead to needless and dangerous surgery or to tedious fixation and inactivity. The sudden onset, absence of fever, short duration and periodic recurrence make the diagnosis usually easy. What the patients require in treatment is rest, encouragement and a flannel bandage. Aspiration of the joint or injections are totally unnecessary. Hygienic measures will often suffice to stop the attack. Angineurotic remedies may be advisable for the patient's general condition and arsenic has sometimes been of service. The arthropathies of tabes and paresis are treated of at more length. The rarity of pain in these cases, the sudden firm swelling, usually rapidly extending, are characteristic in most cases, though rarely there may be pain and the swelling may be gradual. Sometimes the swelling subsides, and the joint is left but little impaired, but more frequently there is a breaking up of the joint and a mild case can be converted into a severe one by neglect and overuse. The painless character of the affection tends to lead the patient to use the joint unless strictly warned against it by the physician. Every joint of the body is liable to be affected, but the larger ones more than the smaller. Two special forms are mentioned; the tabetic foot, in which the bones of the arch are particularly involved, and the tabetic spine, differing from the other types of spondylitis deformans in its sudden onset and extensive destruction of the parts as well as in its associated tabetic symptoms. The joint lesions of syringomyelia are very similar to those of tabes, but the common occurrence of pain, the predominance of involvement of the upper extremities (80 per cent. of the cases) and the longer course of the affection are notable differences. Its treatment is limited to rest, orthopedic measures and the avoidance of trauma. Operative measures are rarely advisable. As regards the theories of these spinal arthropathies, Barker thinks that the neuritic explanation is plausible for tabes, but insufficient for syringomyelia, and that similar objections hold good in the case of the arthritis deformans theory. In conclusion, the painless arthralgias of hysteria and the traumatic neuroses are noticed, and the importance of differentiating them from cases of organic disease, especially tubercular, is pointed out. In doubtful cases the deep chloroform narcosis recommended by Charcot, should be employed for diagnosis. Isolation and psychotherapy are the sovereign remedies for this condition; hydrotherapy and electricity can be useful adjuncts. Brief details of such treatment are given and its suprising success is noted.